DOCUMENT RESUME

ED 131 252 08 CE 008 373

AUTHOR Samuels, William M.; Buckner, Donald E.
TITLE Minority Barriers Identification Conference (Arlington, Virginia, December 15-17, 1975). Final Report.
INSTITUTION American Society of Allied Health Professionals, Washington, D.C.
SPONS AGENCY Health Resources Administration (DHEW/PHS), Bethesda, Md. Div. of Associated Health Professions.
PUB DATE 75
CONTRACT NO1-AH-24274
NOTE 86p.; Not available in hard copy due to marginal reproducibility of original document

EDRS PRICE MF-$0.83 Plus Postage. HC Not Available from EDRS.
DESCRIPTORS *Admission Criteria; *Affirmative Action; American Indians; Bias; Civil Rights; *Cultural Factors; Educational Accountability; *Educational Discrimination; Educational Opportunities; Educational Problems; *Health Occupations Education; Manpower Development; *Minority Groups; Minority Role; Negroes; Program Development; Spanish Americans; Student Application

ABSTRACT

Papers, workshop reports, and pertinent recommendations from a conference concerned with barriers faced by minorities seeking training in the allied health professions are presented. Data provided for the conference, gathered from Northeast, Southeast and Southwest United States during a 2-year period, related to barriers encountered by Black, Indian, and Spanish-surnamed students attempting to enroll in allied health professions in their geographical areas. These barriers were validated and placed under the major headings of need for financial assistance, need for role models, poor academic preparation and lack of tutorial services, lack of career information and counseling, and cultural and social gaps. Five priority recommendations for attacking the barriers were presented: (1) Initiation of a national comprehensive allied health manpower development program, (2) development and enforcement of a strategy to identify and remove culturally biased admissions criteria and procedures, (3) public or private capacitation resource for training centers based on completion of training programs and registration in a profession by minority students, (4) development and implementation of advocacy programs to overcome barriers to minority students entering the allied health professions, and (5) allied health traineeships that would include specific funding for ancillary clinical training costs. A listing of participants is appended. (TA)

Documents acquired by ERIC include many informal unpublished materials not available from other sources. ERIC makes every effort to obtain the best copy available. Nevertheless, items of marginal reproducibility are often encountered and this affects the quality of the microfiche and hardcopy reproductions ERIC makes available via the ERIC Document Reproduction Service (EDRS). EDRS is not responsible for the quality of the original document. Reproductions supplied by EDRS are the best that can be made from the original.

ED131252

FINAL REPORT

MINORITY BARRIERS IDENTIFICATION CONFERENCE

PENTAGON CITY QUALITY INN
ARLINGTON, VIRGINIA

DECEMBER 15 - 17, 1975

SUPPORTED BY
CONTRACT NUMBER NO1-AH-24274
U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

WILLIAM M. SAMUELS, PROJECT DIRECTOR
AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS
WASHINGTON, D.C. 20036

DONALD R. BUCKNER, ED.D., PROJECT DIRECTOR
DIVISION OF ASSOCIATED HEALTH PROFESSIONS
U.S. DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH RESOURCES ADMINISTRATION
BUREAU OF HEALTH MANPOWER
BETHESDA, MARYLAND 20014

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

CE 008 373

AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

ONE DUPONT CIRCLE, WASHINGTON, D.C. 20036 TELEPHONE: (202) 293-3422

EXECUTIVE DIRECTOR
WILLIAM M. SAMUELS

Preface

This is a report concerning a National Invitational Conference sponsored by the American Society of Allied Health Professions under contract number NO1-AH-24274, Division of Associated Health Professions, U.S. Department of Health, Education and Welfare. The conference concluded forty-two months of activity regarding the identification of barriers minority groups face in allied health educational programs. The American Society of Allied Health Professions during the period served as a coordinating body for three regional contractors charged with identifying barriers in the New England, Southeastern and Southwestern areas of the United States. The efforts of the three regional groups were concluded on August 31, 1975. Their findings were made public at the conference which was December 15-17, 1975 at the Pentagon City Quality Inn, Arlington, Virginia. Those findings are available from the Division of Associated Health Professions.

AT THE BEGINNING:

The seeds for the Minority Barriers Identification Conference were sown in Atlanta in 1971 at the fourth annual meeting of the American Society of Allied Health Professions, then known as the Association of Schools of Allied Health Professions.

The Society's Committee on Equal Representation in Allied Health (ERAH) earlier in that year had raised the question as to why less than five percent of the minority groups were represented in the Allied Health Professions. Upon further examination of the question by the committee it was learned that minorities represented about the same percentage in Allied Health educational programs as it was in fields of practice.

The ERAH Committee, then under the leadership of its chairperson Harley Flack, Ph.D., and vice chairperson Frederick Adams, D.D.S., proposed that the Society should consider a national study that would identify the barriers minority groups face within the educational system. The Society endorsed the study proposal in Atlanta.[1]

The study proposal originally called for a national survey for identification of barriers. However, cost estimates soon ruled a national study as prohibitive. In discussions with representatives of the Division of Associated Health Profession, then the Division of Allied Health Manpower, U.S. Department of Health, Education, and Welfare, three regions were selected for study. They were: New England area and upper New York State, but not including New York City; Southeastern United States from North

---

[1] Dr. Flack, now Dean of Allied Health at Howard University, Washington, D.C., was Associate Dean of Allied Health at SUNY Buffalo in 1971; Dr. Adams, now with the State of Connecticut, Office of the Governor, was Dean of Allied Health at the University of Connecticut, Storrs, Connecticut, in 1971.

Carolina,Tennessee, and Arkansas south and Texas as far west as Dallas; and, Southwest United States from Texas and Oklahoma west to Southern California, but not includeing Los Angeles. The urban areas of New York City and Los Angeles were excluded because of urban issues which differ from issues national in scope.

Additionally, two other major changes were initiated because of cost factors. One was a determination that only three minority groups would be included - the Indian-American, The Black-American, and the Spanish-American. The three were selected because of commonalities in discrimination. The other change was to select a contractor for the study in each of the three regions with the Society serving as the national coordinator.

With agreement reached between the Division and the Society on these issues the project was officially started on July 1, 1972 with a contract from the Division to the Society to begin the preliminary efforts. The following Spring contracts were given to the three regional contractors for their work. The three regional contractors were: New England Hospital Assembly (in turn, subcontracted to Associated for Research in Behavior, Inc.), Research Triangle, and Southwest Program Development Corporation. Donald R. Buckner, Ed.D., of the Division was appointed project officer for all four contracts.

Early meetings between the contractors were utilized to determine methodologies and approaches to the problems. However, one of the major agreements between the contractors was to provide for ample public viewing of this effort with progress reports at major Allied Health meetings. In the following months reports were made in Boston, Philadelphia, New Orleans, Chicago, San Diego, San Antonio, Birmingham, Dallas, Long Beach, and Washington.

However, while the efforts were acclaimed in national meetings, issues as to survey documents were building regarding clearance from the Office of Management and Budget. The issues became deadlocked in February 1975. Resolution of the issues concerning clearance involved scraping the survey techniques and utilizing an interview approach at selected academic institutions. The new plan was effected at that time and the interviews were conducted in the Spring of 1975. To provide opportunity to review the efforts of the regional contractors, the Society's role in the project was to conduct a national invitational conference for such a review and to develop recommendations.

Although the efforts of the regional contractors did not result in what was desired at the beginning, neither were the results of the total effort as first seen by the Society and its Committee on Equal Representation in Allied Health and the Division of Associated Health Professions. The changes in course direction, however, were not whimsical. They were caused by significant cost factors.

But the product of the seeds of 1971 was fruitful. The recommendations of the conference have passed a test of examination by those participating in the conference. And the most significant result of all, perhaps, is that a stage has been set for developing mechanisms that could break down the now identified barriers.

TABLE OF CONTENTS

	Page Number
I Summary Report	1
II Papers Presented:	
Mr. Rick Lavis	11
Ms. Marjorie Bear Don't Walk	20
Dr. Donald Buckner	30
Dr. Marna Whittington	33
Ms. Elisa Esler	38
Ms. Betty Murray	42
Mr. Thomas Hatch	46
III Workshop Reports:	
Dr. Marna Whittington	48
Ms. Elisa Esler	64
Ms. Betty Murray	68
IV Recommendations	72
V Attendees	75

The following pages of this report represent the highlights of dialogue and the pertinent recommendations during a December 1975 conference concerned with barriers faced by minorities seeking training in the Allied Health Professions.

Data provided for the conference was gathered from Northeast, Southeast, and Southwest United States during a two-year period.[1] (Each of the three regional efforts was funded by contract from the Division of Associated Health Professions, Health Resources Administration, U. S. Department of Health, Education and Welfare, as was this December 1975 invitational conference which was sponsored by the American Society of Allied Health Professions, Washington, D.C. Copies of the three regional reports are available from the Division of Associated Health Professions.)

The three regional contractors each were charged with the tasks of identifying the barriers minority students encountered when attempting to enroll in an Allied Health training program in their geographical area. Their efforts, however, did not include all minorities, only the Black, Indian and Spanish surnamed.

---

[1] Regional Contractors were: Northeast -New England Hospital Assembly, Inc., Durham, New Hampshire, and subcontractor Associates for Research in Behavior, Inc., Philadelphia,Pennsylvania; Southeast - Research Triangle Institute, Research Triangle Park, North Carolina; Southwest - Southwest Program Development Corporation, San Antonio, Texas.

The recommendations - based on the data provided - are those of the 100 individuals currently involved in Allied Health education (administration, education, students) who were invited from a list of more than 4,000 individuals to participate in the conference.[2]

An assumption by anyone that centuries-old problems and issues would be resolved by studies and dialogue is nonsense. An assumption by anyone that the mores of society in general and academic in particular would be reshaped from years of tradition by conference reports and recommendations is folly.

But the assumption that attitudes are subject to erosion is, by and large, valid and offers feasible goals for objectives of opportunity. Thus, the recommendations of the conferees were made with this thought in mind.

[2] Invitations were sent to the director of minority affairs and the director of student affairs at every academic institution in the United States with at least one program in Allied Health education. Some institutions have neither position; others have the same person in both positions. The list came from the current inventory of colleges and universities with Allied Health educational programs which is compiled by ASAHP. Other invitations were sent to the deans of ASAHP member schools and to selected lists provided by the regional contractors and HEW.

The conference was designed to accomplish three goals. The first was for the conferees to examine the barriers so identified within the three regions and validate these barriers against their own experiences and knowledge as Allied Health administrators, educators, or students. The next goal was to arrive at feasible solutions that could reduce or possibly eliminate the barriers that had been identified and validated as real. The last goal was to give priorities to the feasible solutions.

To provide for maximum utilization of the conferees' time during the 2½-day conference, 1½ days were devoted to working parties wherein the participants were assigned to a workshop with the charge to attain the initial two goals of the conference. The three workshops were designated by the three regions from which the data was gathered and the conferees were assigned as working parties to the region nearest their home area, insofar as it was possible.

So that each of the three working parties would have a baseline for discussion in the workshops, the initial half-day of the conference was devoted to overview presentations. The first two overviews were national in scope; the remainder of the presentations focused upon the three regions.

The national overviews were given by Mr. Rick Lavis, senior legislative counsel to Senator Paul J. Fannin (R. Ariz.), and Ms. Marjorie Bear Don't Walk of Helena, Montana. Mr. Lavis prepared the Jackson-Fannin Bill for Indian Health Manpower Education which possibly could become the model for health manpower education for all minority groupings. Furthermore, the bill provides the most active initiative for minority

programs within the health manpower education proposals of the Congress. Ms. Bear Don't Walk not only represented a geographical area not included in any of the three regional studies, but has been involved in minority recruitment into the health career fields in western United States and serves as a consultant for several national agencies involved in minority recruitment into health careers.

Regional overviews were presented by Dr. Donald R. Buckner, Division of Associated Health Professions; Dr. Marna C. Whittington and Dr. Stephen D. Benson, Northeast region; Ms. Elisa P. Esler, Southeast region; and, Ms. Betty Murray, Southwest region.

Following these presentations the three working parties began their workshop deliberations for the next one and one-half days. The conferees reassembled in general session the morning of the third day to hear reports from each working party as to feasible solutions to reduce or eliminate the identified barriers and to establish a priority system for implementation of the proposed approaches that would lead toward an erosion of current attitudes.

By and large, the working parties' reports did validate the barriers identified by the three regional studies. And, furthermore, the barriers identified in each region all had common denominators and could be placed under major headings: Need for Financial Assistance; Need for Role Models; Poor Academic Preparation and Lack of Tutorial Services; Lack of Career Information and counseling; and Cultural and Social Gaps.

A total of 17 recommendations as feasible solutions for attacking the barriers were presented by the working parties. Of these, five were ranked as top priority; the remainder were considered as approaches with lesser priority.

The five solutions considered to be the most urgent to implement were:

1. Initiation of a national comprehensive Allied Health manpower development program that would include: (a.) statistics relating to minorities in Allied Health educational programs; (b.) universal definition of the Allied Health Professions and certification standards and registration requirements; (c.) counseling programs to provide minorities with information as to Allied Health careers, academic requirements, training costs, and financial resources; and (d.) the provision of Federally funded comprehensive supplemental services for minority students, such as financial assistance, counselor education, alternative career counseling, tutorial services, child care, housing and transportation, and health and nutrition services.

2. Development and enforcement of a strategy to identify and remove culturally biased admissions criteria and procedures, such as more effective entrance criteria in relation to the GPA, SAT, and interviews; adequate minority representation on admissions committees; and, interviews held near students' homes.

3. Public or private capitation resources for training centers based on completion of training programs and registration in a profession by minority students.

4. Development and implementation of advocacy programs to overcome barriers to minority students entering the Allied Health Professions.

5. Allied Health traineeships that would include specific funding for ancillary clinical training costs.

Of these five primary recommendations two (recommendations #3 and #5) involve legislative authorizations and in all probability could not be limited to minorities, per se, as capitation and traineeships would have to be applicable across the boards. The legislative authorities to implement recommendation #1 could be minority oriented, however.

The other two priority recommendations are geared more for the private sector, rather than the government agencies. As to whether private sector agencies would be the professional societies or educational associations or combinations of both is a determination that will have to be made by each organization concerned with the problems and the issues.

Other approaches of lesser priority for consideration in attacking the barriers are:

1. The utilization of state-level organizations in dissemination of new and existing information regarding Allied Health educational programs to both the schools and public-at-large; coordinating such efforts with the existing mechanisms and professional societies.

2. The development of standardized data about Allied Health manpower that includes minority group representation within the Allied Health Professions and the geographic distribution of minority groups employed as Allied Health Professionals.

3. The development of information transfer systems, both active and passive, and at various levels of detail. The systems would be formal (e.g., educational systems, libraries, state and professional organizations), informal (e.g., periodicals, exhibits, radio-TV), and community groups (e.g., religious, civic).

4. The development of strategies that would establish cooperative arrangements between schools with sizable minority populations and health care institutions for the training of minority students in an Allied Health Profession.

5. The development of strategies that would establish cooperative arrangements between schools with sizable minority populations but no Allied Health educational programs and schools of Allied Health to provide training programs for minority students in an Allied Health Profession.

6. An examination of program structures with the objective of increasing flexibility such as open entry/open exit, no drop policy, guaranteed clinical affiliations, and competency based instructions.

7. Distribution of materials describing the efforts of this conference and its recommendations to educational and professional periodicals and journals, systems of instruction, and all other interested persons and agencies.

8. Development of comprehensive support systems for minority students in Allied Health educational programs that would include advocates, advisors, peer support, tutors, fiscal assistance, and early warning of problems.

9. Development of statistical documentation regarding populations within the Allied Health Professions and that distribution be made through publications and to agencies and institutions involved in the training of minorities in the Allied Health Professions.

10. Assurances that public funds be allocated only to programs providing equal access to minority students.

11. Examination of course structure wherein Allied Health students compete with pre-med, pre-dental, and pre-veterinary students to determine if Allied Health students need all of the course content given to pre-med, pre-dental, and pre-veterinary students.

12. Development of a closed looped system for increasing minority student representation through recruitment, application, matriculation, and completion.

The above approaches of lesser priority, by and large, would follow after the implementation of the five priority recommendations. However, it is possible and feasible that each of these could be implemented without the five recommendations having been activated.

The priority recommendations are national in scope whereas the lesser priority approaches focus on local, state and region activities. For example, it would be most difficult to enact any of the five recommendations in a geographic area less than a state, as legislative authorities and/or considerable funding would be needed. The dozen lesser approaches for the most part are strategies that could (perhaps should) be developed at less than the national level.

But regardless of whether the recommendations are implemented, collectively or in part, it must be remembered as it was said earlier, these considerations by the conferees are based on the assumption that attitudes are subject to erosion, but not overnight change. None of the foregoing conclusions suggest that implementation would bring overnight changes. These considerations would effect a shifting of attitudes, however, and in turn would begin erosion of the barriers which now exist.

This Invitational Conference perhaps should be called a working party. For the three days of this session, everyone will be working toward finding solutions that hopefully will reduce if not eliminate some of the major barriers minorities face in allied health educational programs.

The selection of invitees was done to assure that knowledgeable people who are involved and committed are in attendance. Therefore, this is not an orientation conference—it is a working conference.

Prior to this meeting, three years of work was done in three regions of the United States: New England, the Southeast, and the Southwest. As with this conference, the work was accomplished by contracts with the Division of Associated Health Professions.

This conference is to begin with the data gathered by the three regional projects. The goals to be accomplished at this conference are: to examine the barriers identified, to offer feasible solutions to eliminate or reduce such barriers, and to set priorities for effecting change.

CONFERENCE AGENDA

Monday, December 15

8:30 a.m. Registration

9:00 a.m. Plenary Session — **East Ballroom**
Moderator: William M. Samuels
Executive Director, ASAHP

Greetings: Thomas C. Barker, Ph.D.
President, ASAHP

Overviews:
- From the Congress—
  Rick Lavis, Senior Legislative Assistant to Senator Paul J. Fannin (R. Ariz.)
- From the Professional—
  Marjorie Bear Don't Walk
  Helena, Montana

10:15 a.m. Coffee Break

10:30 a.m. Regional Project Reports — **East Ballroom**
- New England—
  Stephen D. Benson
- Southeast—
  Elisa P. Esler
- Southwest—
  Betty Murray

12 noon Luncheon

1:30 p.m. Working Sessions— **Mezzanine Parlors**
New England (Parlor A)
Southeast (Parlor B)
Southwest (Parlor C)

4:30 p.m. No-Host Social Hour — **East Ballroom**

Tuesday, December 16

9:00 a.m. **Working Sessions—** Mezzanine Parlors
New England (Parlor A)
Southeast (Parlor B)
Southwest (Parlor C)

12 noon **Lunch** (No function scheduled)

1:30 p.m. **Working Sessions—** Mezzanine Parlors
New England (Parlor A)
Southeast (Parlor B)
Southwest (Parlor C)

4:30 p.m. **No-Host Social Hour** East Ballroom

Wednesday, December 17

9:00 a.m. **Plenary Session** East Ballroom
Moderator: Donald Buckner, Ed.D.,
Project Officer, Division of
Associated Health Professions

Reports of the Working Sessions—
- New England
- Southeast
- Southwest

10:15 a.m. **Coffee Break**

10:30 a.m. **Where Do We Go From Here?** East Ballroom

12 noon **Adjournment**

INVITATIONAL CONFERENCE CONCERNED WITH MINORITIES' BARRIERS IDENTIFICATION

December 15-17, 1975
Pentagon Quality Inn
Arlington, Virginia

Sponsored by the American Society of Allied Health Professions under contract by the Division of Associated Health Professions, U.S. Department of Health, Education and Welfare.

MR. RICK LAVIS (Senior Legislative Assistant to Senator Paul J. Fannin):

In five-and-a-half years with Senator Fannin, the one great achievement I feel very good about -- and they are few and far between in my business -- is what we did with health manpower in the Indian Health Care Improvement Act. And so it is my pleasure to talk a little bit about it and to discuss what kind of approach we took, how we did it, and why we did it, because there are four or five different titles to the Indian Health Care Improvement Act, and the Health Manpower Section -- and I think significantly so -- is Title I, and this was really a minority presentation or approach.

The Republicans are the ones who put this package together. The majority, Senator Jackson's staff, were assigned the responsibility for patient care services and construction problems. But Title I was ours. It was something that we really enjoyed doing because we really had to take a very hard look at what the Federal Government was doing, what its approach was, and whether that approach was making sense and whether we were going to have the chance to deal with some very difficult problems in terms of manpower in regard to Indian health care.

To begin with, the dimensions of the problems that we were confronted with were basically two. One, we were confronted with the fact that the Indian Health Service didn't have enough manpower to meet the needs of the Indians. In my trips around the Southwest, particularly Arizona, this came home very clearly to me. For example, when I visited in Sacaton I found that their particular hospital was set up in such a way that they only had one nurse at night to run an entire ward and take care of some difficult problems. At the same time, they didn't have enough manpower to watch over

the new baby unit. As a result, I sometimes wonder how some of these young kids survive in that situation, because they were left in such a way that people could not keep track of them. That brought home the manpower shortages to me very clearly.

Another one - in the Navajo Reservation. There was a report from the United States Civil Rights Commission that babies were left with a bottle or a straw or something left on the side of their mouth while nurses and others had to go and do other things because the shortages were so great.

And this isn't just shortages in physicians. It is shortages throughout the whole service, what you call allied health professionals, doctors, nurses; you name it, the shortages were there, clearly.

So that was the first glaring error, the fact that the Indian Health Service, which serves reservation Indians, does not have enough people to take care of the job. And I am sure Majorie Bear Don't Walk can tell it to you more graphically, because she has been there a lot longer than I have.

The second thing that came home to us very clearly was that we don't have enough Indians as professionals. Most of them were janitors. We didn't have enough administrators. There are only four doctors in the Indian Health Service and maybe two or three beyond. They are outside in private practice, and most of them aren't on the reservation, and that is where they are needed.

So that is what we are confronted with. We are confronted with a shift in demand too, because here you had all these -- for years many Indians were afraid of the white man's medicine, even though the Indian Health Service was there and doing a particularly good job under very trying

circumstances. But until recently, most Indians weren't really interested in the Indian Health Service. Now the younger Indians are coming in droves to accept these services. The demand is great, and they are just overwhelmed.

So we had to produce legislation which would address that problem.

In our analysis we found a number of things. We found that the existing programs were absolutely inadequate. First of all, in terms of producing a method by which we overcome the shortages, we found that existing programs did not link the recipients directly to the Indian Health Service; we found, where we found doctors being trained, or nurses or allied health professions, that we had no way of getting those individuals into the Indian Health Service.

We didn't have enough programs which would recruit Indians or even non-Indians to make up the need. And we didn't have enough programs, or any programs, which would provide adequate financial support. I will get into that a little later, because that is probably the most critical thing that we found, especially with regard to Indians.

And, finally, most Federal Health Manpower programs, the Physicians Shortage Act, the National Health Service Corps, only serving a very limited clientele. In other words, just producing doctors and maybe some nurses or dentists but not down at the allied health level. So you only had a very limited number of people being served. And sometimes you had need of allied health professionals more than you did of doctors.

The BIA, for its role, while it had a substantial scholarship program, is more interested in turning out lawyers than educators. So there wasn't any relief there. Even if we moved in that direction, then we would have to be making some judgments, priority judgments, with regard to that area.

We want to produce lawyers; we also want to produce educators, predominantly educators.

We were confronted with some very difficult problems. And our response was to produce legislation which would deal with that. The first thing we did was to put together a package program. Before I get into that, let me make just one other comment on this legislative development.

We made a commitment at the outset that we would give the Indian Health Service an Indian Health Care Manpower Program. Up to that point all these programs were scattered hither and yon in HEW and in BIA and others. But, as I indicated before, there was no linkage, and with a lick and a prayer maybe, the Indian Health Service would pick up what it needed, but it couldn't control events. That was a difficult thing. We had to give the Indian Health Service the authority, the ability, to deal with the manpower shortages it was confronting, and under the prevailing circumstances, it couldn't do that.

We decided we will give the Indian Health Service the authority -- we will give it its own program, let it set the standards, let it set the priorities on what it needs. Maybe one year they are going to need a lot of doctors, which is the case at the moment. But down the line, they are going to need other people, the allied health professionals, the nurses, the dentists and everybody else. Let them make those judgments as they go along.

We set up four basic programs. We set up a recruitment program to give the Indian Health Service the mechanism to go out and recruit people, to recruit young Indians who are interested in the health care professional program.

Then we had a preparatory program, a scholarship program, a compensatory program, so if you had situations in which the educational development of young Indians was not sufficient to prepare them for a very rigorous academic program, like that required in the health profession areas, we would provide that additional help.

And then we got to our scholarship program, which is the key to this whole effort.

We said first, we would give a scholarship to either non-Indian or Indian alike, who is qualified, and we would give them full tuition plus expenses up to $8,000 per year, in return for which they would serve in the Indian Health Service one year for each year of scholarship assistance.

Now, that doesn't necessarily say that it is entirely in the Indian Health Service. We did put a provision in the Bill which said that in those areas where an Indian or non-Indian who participates in this program could find or locate a private practice service area close to the Indian Community and would be serving predominantly Indians, that would qualify as a service payback opportunity.

But the interesting thing here is that this scholarship provision is the richest one around, if this goes into effect. The reason we went up as high as $8,000 plus tuition is that we found that most Indians, in terms of that objective, were without the kind of financial wherewithal to contribute to their own financial assistance. So we had to go up that high.

I heard one horror story out of Oklahoma where a young Indian was going to school. He was through his second year of medical school and could not go on because he did not have enough funds.

The difficulty here is that many scholarship programs are so uneven that the young Indians have to go out and put together a package, making

it awfully difficult for them to continue. And those packages are usually just not enough.

We found, for example, in dealing with the Indian student that the average age of the Indian student is 26 years old. We found that he has about three dependents. Fifty-eight percent are married. Sixty-eight percent of them have to travel out of their region. So that means that when they are going to school, they are going to be paying out-of-state tuition, which is considerably more. The transportation cost, we found, is usually $200 per person.

The usual scholarship amount is just not enough. So we had to go to a high amount. Now, that doesn't mean that is the total amount they get. The total amount on what they can contribute. But because they cannot contribute that much, we want to make it under such conditions, give them enough money that they are going to be able to get through school. We think that it will happen this way.

The last element in this package is what we call our continuing education program. We found through the General Accounting Office studies and others that a major reason why individuals, mostly non-Indian on this basis, do not want to go out to the reservation or even into other areas is the fact that they have little chance to participate with their peers in educational opportunities and professional opportunities.

If you go out in the reservation area, like at Window Rock, which has got to be the end of the world, you don't really find many opportunities to sit down with your peers and discuss the intricacies of an ulcer or something along these lines.

What we want to do is establish a program whereby those participating in this program could then go back for continuing educational opportunities.

This whole effort was a series of interrelationships and we tried to work it together. And, again, it is all assigned to the Indian Health Service.

In setting up this kind of program, we made some very definite assumptions, and some rather questionable ones. We think it is going to work, but we really don't know.

We know that the existing system doesn't produce the kind of climate nor the conditions for encouraging Indian health professionals. But we think that through these kinds of incentives, we are going to attract people to this kind of program. We think that through this kind of financial arrangement, we are going to attract greater numbers of Indians, because really the long-range best interest of the Indian Health Service or health care on the reservations is through Indian participation.

We don't have enough administrators in that program. We have very few physicians, very few dentists, and clearly not enough allied health professionals on the front line in dealing with Indian people.

I am sure that Majorie will tell you that there is a tremendous conflict at times between "white eyes", as she will call them, and the Indian himself or herself. It is a very difficult cultural situation.

The other assumption we made is that we think this program will result in greater numbers of Indians and non-Indians staying on the reservations to serve Indian people.

That is a very questionable assumption. I don't know if it is going to work. There are some who say that if you take an Indian, put him in a medical school three or four thousand miles away from home, the likelihood

of his coming back, or if he does come back, the likelihood of his staying will be very minimal. He will have seen too much and participated in too many opportunities for him to want to stay very long on the reservation.

Some say that the only way to overcome that is to establish what is known in the Indian community right now as the American Indian School of Medicine, a program that Dr. Taylor McKenzie and a Navajo Tribe are setting up. It is an attempt to put together a program on the reservation itself in New Mexico and Arizona where these Indians will go to school at this particular medical school. That will afford them the opportunity to remain on the reservation serving Indian needs. That itself is an assumption.

In conclusion, let me make a few overview comments about minority health care education and Indians, because there are very clear distinctions.

The first distinction, federal policy, is that in this particular case there is a unique federal-Indian relationship that is known in no other area, particularly in regard to minorities. Because of the treaty relationships between the Indian tribes themselves and the Federal Government, the federal policy is to encourage and work very closely with Indian tribes directly. I don't know of any other kind of relationship that exists along those particular lines.

There are unique geographical and cultural differences, as compared to the general population. There are very definite language barriers. There are very definite differences in the relationship of the Indian to modern medicine or to doctors. In fact, in the Indian Health Care Bill we are not content with just producing more doctors and nurses; we are also

supporting the old traditional Indian practitioners, the medicine men, who are of tremendous assistance because they are often the bridges between modern medicine and the old ways.

Finally, there are some geographical differences. I am not very proud of this, but the fact of the matter is, we have reservations. The reservations are not exactly on the best lands of this country. All you have to do is visit places like Kechon at Yuma or the Papagos sometimes. It is hot, arid wasteland. It is not paradise on earth, I assure you. That is where the Indians are, that is where the problems are. All those problems are part of the environment; they contribute to problems in health. And that makes it unique and different.

I would like to say that what we are trying to do in Congress in this particular field is to deal in the short range with the problem by producing more doctors and nurses to serve the Indian Health Service. The long-range goal is to overcome the existing program and system barriers that exist with producing those kinds of doctors, Indian doctors. That is what we need.

I think that S. 522, the Indian Health Care Improvement Act, really addresses those issues. But we have some rather definite questionable assumptions that we operate under, and we hope that they prove out.

MRS. MARJORIE BEAR DON'T WALK (Helena, Montana):

First of all, I no longer work in the allied health fields and am not associated with anything but some of the consulting work I have been doing recently.

You have just heard about a bill in Congress to upgrade the health of Indians. It has been long in coming. What wasn't told, was that this is not the first year that bill has been in Congress. It was in Congress last year, and it passed the Senate but did not pass the House. It has been revised a couple of times.

I am hoping that the people here will see fit to support the Senate Bill 522 and H.R. 2525.

I could give you statistics on Indians that would give you an idea of why this bill is needed.

First of all, most of the time, in dealing with Indian health professionals, you can count them on one hand, if you can count them at all. There are very few Indians in the health professions. There is one vet, one Indian vet in the United States. There are, at last count, about 55 Indian physicians. There are about 200 registered nurses. There is one dentist that I know of. There are very few Indians in health professions.

And for good reasons. This system in the United States alienates minorities and low-income people. I am really amazed at why we are here. I am kind of amazed at the studies also.

I don't think you have to look very far to see why we have spent all of this money on these studies and why we are here talking about the barriers. We have a social system in this United States that alienates low-income and minority people. We are sifted out before we ever get to school.

When you are born, if you are born to low-income or minority people, you are generally born to parents who have bad health, who have no education, who are low-income, who are in substandard hospitals.

You know that is the start some of us get. I did not have a couple of grandparents because the white people who came to this United States brought some illnesses that my people had no resistances to. My grandmother died at the age of 31 of TB, and two of her sisters died at the same time.

My mother, when she was 12, got TB also and spent six years in a TB sanitorium. When she got out, she had seven unhealthy kids. And we in turn have produced unhealthy kids. We have produced unhealthy, low-income, uneducated kids. The system has been perpetuated.

I went to a conference last week on upgrading women in health. It was kind of a women's lib type group on upgrading education for women. I was more than a little upset because we have developed an elitism of professional people. I can go to any professional group and in most cases not understand the vocabulary that they are talking with. It took me a day out of the day-and-a-half to figure out what was going on, first of all. And, second, the professional people who are developed in this country have educated themselves to the point that they no longer communicate with the people that they are sent out to help.

I am not a health professional either. I have a degree in home economics. The reason I have a degree in home economics is that when I was very young, my mother tried to get me to sew because I had all of these brothers and I was a really bad tomboy and I used to fight and do all of these other things and she wanted me to become a little more feminine. So I have always been able to sew. I was kind of pushed into a home economics teaching degree so that I would have a job, and teaching was at the time the profession you went into if you wanted to work.

So I am not really a health professional but I have worked in areas of health dealing with minority people because, first of all, I have been

very unhealthy, my family has been unhealthy, and there is no way that you can help low-income or minority people without dealing with their health.

There is another area that we seem to miss when we talk about education. I have recruited Indian students into health careers. We would go out to the reservations and we would go to the schools, that is if you can get into the schools. A lot of the administrators perpetuate their systems of high pushout rates of low-income kids by not letting the people who want to help these students into the schools. They say these kids have missed too much school, we don't want anybody in.

So we go out and we recruit and they don't let you in; so you don't talk to these students. But you do get into some schools and we talk to those students.

Does anybody consider their health -- if you're malnourished, if your health is bad, can you concentrate? Can you stick with something? I think we have to look at these things. Do we have adequate nutritional programs for these students?

I was interested in a couple of things that Mr. Lavis talked about over here. The students that I have dealt with are basically low-income, are basically malnourished, are basically uneducated. They may have a high school degree, a high school diploma; but what did they learn?

I got out of school without learning how to write. I got out of college without learning how to write. I never really learned to speak very well. I did all right in math but my English was terrible. Most of the students that I deal with have no math, no science, no reading, no writing background.

The educational systems in this country are failing everybody, not only minorities. But you should see the schools on the reservations.

You take this student and you say, Well God, what happened to this kid? He'll never make it through a medical career. So you say, what about the money for this kid? It is going to take him five years to get through his B.A. degree, if he makes it.

One point I missed along the road is that there is an extremely high dropout rate between the fourth and the tenth grade on Indian reservations. I would say that right now on my reservation 50 per cent of the students are not making it to the tenth grade.

I can name you one school I worked at where the dropout rate was up to 96 percent.

Now, why is this so? We are talking about students who have made it, but what about the students who haven't? We have school boards who are anti-minority, who are anti-low-income, who perpetuate the social system in this United States. The social system is: If you are not the right color, if you don't have the right income, if you are not at the right social status, you are not acceptable.

The reservation I come from is the Confederated Salish and Kootenai Tribes of Northwestern Montana. We have organizations on our reservation to terminate the tribes. That means that Federal recognition of the Tribes would no longer be there. These people are the majority of the people who are on the school boards, they are a majority of the people who run the institutions on the Reservation. They're 50 percent of the population of our Reservation. They are the people who run the churches. They are the people who control the education of the Indian people from my Reservation.

You have to ask yourself: Do these kids have a chance? Are we setting them up for failure? In most cases we are. They have to be very tough to make it. And when they do make it, what is the price?

This bill looks really good. But it is not enacted yet. The chances of its getting through Congress, I have to ask, what are they?

In the meantime we go without the other things that people have who are in the mainstream.

And they are kept out of the mainstream. There is an elitism here.

I have to also ask, in the research studies that I looked at there, where are the statistics for Indians? They are not in there in most cases. If you develop a program like the research studies that are there to get numbers and names to develop programs, I guess the purpose is that with those numbers we develop programs to overcome the problems that we have. If there are no numbers there, where has it gotten us as Indians?

I can tell you that my life expectancy is 42 years. I am two-thirds of the way down the road.

I heard an interesting theory last week. That is, if you are only expected to live to be 42 years old, don't you think that the age when you are considered to be elderly should be lowered?

I am going to be 30 in a couple of months, and I would like to apply for Social Security right now, because I have only 12 years to live.

One thing about Indians is that we have a high birth rate. I would like to tell you that we are going to overcome the rest of the population of the United States, but I don't think we are ever going to work that fast.

Along with our birth rate, we have a high infant mortality rate, very high, higher than any other minority in this country and higher than any other minority that you come up with statistics for. It kind of goes along with some of the underdeveloped countries.

The suicide rate for Indian teenagers is at least twice the national average. There is an identity crisis of the [illegible] what am I going to do?

You come from a school that doesn't educate you. You live in a social

system that doesn't want you because of your color, your income, your social status. Where are you going? What is going to make you acceptable? And I can tell you, only two things - money and education.

Any program that we develop is a Band-Aid program for the social system of this country. The social system, until it accepts us, until it accepts people who are not all the same, who are different colors and different incomes and who have different cultural values, will hurt and will need Band-Aids until it can grow to be more open-minded than it is right now.

We heard a little bit about the BIA's law program and educational program.

In about 1966 they tried to count how many Indian lawyers there were in this country. They could count them on one hand almost. Actually there were six. It depends on how many fingers you have got, I guess.

So they said --We have entered into treaties, our tribes, and yet most of us are not able to read what those treaties said because they were written by attorneys. So they decided that we needed attorneys and they developed a program specifically to put out Indian attorneys. That program has been very successful. They put a lot of money into it, they put a lot of expertise into it, and they have trained a lot of people from the ground up, and it has taken years.

I can tell you about that program from experience because my husband graduated as an attorney last June. He is 34 years old. We have got three kids. And it has taken a long time.

When you become an Indian professional, you pay an extremely high price for joining this system. The programs that you go through will teach you values that will conflict with your own, and you have to wonder where you are.

I have seen doctors -- we have this term, professionalism, and it

is the same thing that attorneys have. You learn to become a professional and you give up all of your beliefs and cultural values and you buy what they tell you, if you want to graduate. So when you graduate, you are out there on a limb farther than you have ever been before.

When you get an education, you set yourself off from the tribe. You are kind of over here, you have got some white man's education. When you get a doctor's degree, you are so far out on that limb, you are all by yourself. It is really lonely out there. People are expecting things of you that are completely inhuman. You have all these answers and you don't have any personal problems.

But you do the same thing with health professionals because you have joined a group that you don't fit into. One of the mistakes of education of Indian people is that you alienate them from their tribes. You take them out and you keep them from four to eight years or longer and you teach them the white system. When they go back, they no longer communicate with their people because they have picked up a new terminology, they have picked up new values. That is the reason they don't stay on the reservations. They don't fit in and people don't accept them.

So I say when you develop these programs for minorities, develop work programs so that they work with their people from time to time, so that they keep those communications open, so that they don't go back as educated people who are going back to tell the people what to do and where they went wrong. So that when they go back, they go back to learn from their own people. Their own people have things to teach them. They go back and they learn and they can keep those communications systems open. That is not happening now.

You go and you learn all these things, these studies about monkeys and all this kind of stuff, and you don't relate. And the vocabulary that you have picked up is way up here and makes the people you talk to feel

inferior. And so they pick up defenses to you.

My brothers come to my house and they say, Jesus Christ, I thought you had a degree. Look at this joint, wash that kid up, do this, do that. And that is all right, because they still relate.

I would like to make that point really clear. We become so professional that we are failing to do what we set out to do. How can you meet the health requirements of people when you don't talk their language, when you look down on them as being poor and malnourished and having all of these problems?

I have seen it happen over and over again. These nutrition programs that are set up, these dieticians come in dressed fit to kill, driving their new little cars in, and they are going to tell you what you are doing wrong and what you should be eating. You don't have the money to do what they are telling you. First of all, you don't like to be told that you are doing things wrong when you are doing probably the best you can under the circumstances.

A nutritionist I have worked with says that malnourished people can only deal with short-range problems, we can only deal with today. A person who is well-fed can deal with long-range problems, they can see what the results of their actions today will cause tomorrow. If you are malnourished, the decisions you make right now have no bearing on what price you will pay for it tomorrow. You take a look at the people you deal with and see how that relates to them.

I had a student last year -- I worked for two years recruiting students and helping to retain the students at the University of Montana. At the end of the quarter when she was running really low on money, they never got very much in BIA scholarships to begin with, for the last three weeks she subsisted on only pistacho nuts. Her disposition was never good to begin with,

but it got absolutely rank because she was malnourished and she had to go through finals and she had to deal with all of her problems and she was not eating properly. She didn't have money.

I would like to wipe out a little thought here about the BIA scholarship fund. It is inadequate, it is underfunded and the students who go starve in most cases.

When the Indian people of this country involuntarily gave up most of their land, the treaties said that in return for the land we will give you health and education. They never have.

If you want to give the land back, we will develop our own educational systems and our own health systems. I don't see that day coming. So I expect the United States Government to live up to its treaties. That day has got to come yet. The education that we as Indians are receiving is inadequate in any form that you look at it.

The BIA scholarship last year was underfunded by 12,000 students. They estimated that 32,000 students would attend college, and the United States Congress funded it for 25,000 students. Or have I got that wrong? There were 22,000 students. When these students sent in their little applications, there were 12,000 of them who were turned down. And those who were funded were funded at a bare minimum.

How would you like to go to school when you have spent your entire life undereducated, underfed, underfunded, and you go to school and you have got to find housing, you have got to try to eat? The inflation cost last year of paper and books went up unbelievably. So you get to the end of the quarter and you're not eating and you have still got to go home, you have got to study and you have got to pass those finals and you can't read or write very well. What are the chances of success? Are we setting these kids up for failure? We are. We continue to set them

up for failure at best with this Band-Aid program.

And it is only a Band-Aid program until the system changes. At best, with that program we are still not going to be meeting the needs of the people.

When the elderly Indians are malnourished and are poor and are back home and are looking for somebody to help them out and they are not there and we are not producing them, you have to wonder what keeps these people going. I think the only way you are going to get an idea of how Indian reservations are or urban Indian centers is to see them for yourselves. If you ever get the chance, don't miss it.

We can talk about minorities in this country, but we were here first and we are being served last.

I looked at the studies, and I had to look fairly hard to find anything about Indians. And I did find one. It was in the Southwest study.

The whole name of the ballgame is very clear to me and I hope I have gotten it across to you. If you have any questions, I would be really happy to answer them. I could rattle on for a long time now.

We need to change the system, and that is about the only thing I can tell you. The problems will continue until we do.

DR. DONALD BUCKNER (Project Officer) Division of Associated Health Professions, HEW:

In 1971 some minority members affiliated with the American Society of Allied Health Professions -- then the Association of Schools of Allied Health Professions -- expressed interest in why so few minorities were enrolled in allied health training programs and practicing in the allied health professions.

A study had already been funded through our Bureau to identify and evaluate the progress of one of our Bureau's programs. Statistical data from that study indicated that only 3 to 5 percent of the students enrolled in allied health programs were minority students. It was recommended that a study be conducted to determine why minorities were so poorly represented in allied health education and practice.

It was decided that we would take up the recommendation to do an actual study to identify those barriers.

The Division advertised to determine organizations interested in conducting such a study.

We received 92 applications as a response. It was the largest number of respondents to any kind of contract advertisement that we had in our Division.

In view of the funding limitations, the scope of the study was limited to three geographic areas: the Southeast, the Southwest, and the Northeast regions of the United States. It was thought we would concentrate on those areas where the problems were most likely.

A separate contract was awarded for each of the three regions, the rational being that we could get recommendations and statistics as to what the problems were in the various training programs from someone who was actually in those particular regions.

The three contractors who won the competition were the New England Hospital Assembly at Durham, New Hampshire, which actually developed a subcontract with Associates for Research and Behavior, Philadelphia, (Northeast Region); the Research Triangle Institute in North Carolina (Southeast Region); and the Southwestern Program Development Corporation, San Antonio, Texas, (Southwestern Region).

There were some geographic limitations in the contract. The city of Los Angeles was not included in the study. The area south of Los Angeles east to Dallas, Texas,was designated Southwest Region, covering seven states. The Southeast Region extended from Dallas, Texas,east, covering seven states. The Northeast Area had seven states, but excluded New York City.

The major urban areas were excluded from the study in order to avoid immersion in special urban problems which would have drained our financial and manpower resources.

Three minority groups were identified for study: the Indian-American, the Black-American, and the Spanish-American.

There were some thoughts that the Oriental group should be included. However,the earlier study, referred to in the beginning of this report, indicated that the Oriental groups were doing relatively well in the allied health professions and did not have the same problems of discrimination experienced by the other three groups.

The three contractors to go into the areas and gather together people who are actually in the training programs or conducting the training programs; people concerned with funding; people concerned with admissions, and to learn what their perceptions were of the barriers in allied health. The results of this effort are detailed in the three attached [illegible].

A fourth contract, initiated prior to the three regional studies, was awarded to ASAHP to coordinate the regional projects and to compile this final consolidated report.

DR. MARNA C. WHITTINGTON (Co-Director, Associates for Research In Behavior, Inc., Philadelphia, Pennsylvania):

It is difficult to summarize two years of work and 40 pounds of computer analysis and 80 hours of tape into a few minutes. So I would like to touch on the highlights and skip over the methodology as much as possible to give us somewhere to start this two day conference.

First, our methodology was somewhat different than the other two contractors' in that we looked at our data in two ways. We used a standard objective analysis of our focus group sessions, i.e., how many times were barriers mentioned by students and faculty? How much time was devoted to each barrier? And in that way we prioritized the barriers.

Secondly, we did a factor analytic-based analysis using a Lafal content analysis technique to try to get at the underlying emotions or thoughts that weren't stated in the words. This is a new technique that I think is very promising for this kind of research because it is very difficult to sit down with a group of people, establish instant rapport and two hours later really get to the heart of how they feel discriminated against and what they feel the barriers are. This technique allowed us to do that in many instances.

I think before I summarize our results, I would like to say that we found that the barriers to minorities are not specific to minorities alone. The same barriers apply to all individuals who are interested or potentially interested in careers in allied health. The problem seems to be that stochastically or probabilistically these barriers are more likely associated with minorities because of the public school situation, because of the experiential background, because of

the social situation, and because of the economic situation. They are not unique barriers but rather we find them more frequently as barriers to minorities.

Basically the major barrier and one that we estimate probably accounts for 80 per cent of the variance in the situation is the knowledge barrier. An allied health career is not a viable career if you don't know that it exists. If you only know about nurses, if you only know about doctors, maybe social workers, maybe dentists, and all you know is that they are the people that walk around in white uniforms and work in a hospital, you don't have much to reach for and that in fact seems to be the basic problem. Our minority students are not aware of the vast number of opportunities in allied health professions. They are not aware that they can get into areas that require only six months of training as opposed to eight years of training. Those who are aware that there are such things as professions in the allied health area don't know what they need to get into them. They don't know what schools offer courses. They don't know how to find out about the courses.

We did a study that Don helped us in. It was really Don's idea to test how unique the knowledge barrier is to minorities.

The allied health professions are careers that one generally enters training for directly out of high school. Therefore if a student is not learning about the allied health professions through their home situation or through their experiential situations the question becomes what information is the high school offering?

We found even in one of the most professionally-oriented high schools, non-minority, the teachers couldn't name on an average more than six allied health professions. Not only that, they didn't know where to find information about them and they didn't know what the

requirements were to get into them.

So our basic recommendation for this program is, one, spread the word about what is available, what it takes to get into it, what you need.

And, unfortunately, this knowledge barrier is very interactive with all the other barriers that we found.

The second major barrier was preparation. The minority student is at a disadvantage, even once in a program, if they are trying to compete with a majority student. Often times they have been tracked in high school and don't have the science and math courses. They haven't known to take the basic science and math courses. Even in high school when they discover they need them, they are seniors or juniors and it means taking two at once in the same year, when they are tough courses, or it means giving up the idea of allied health or spending an extra year trying to catch up on remedial courses.

And I think here again our minority students, for the most part, are in an economic situation where they can't afford that extra year. Economically they can't afford to spend a year picking up courses they don't have, getting up to par in courses for college that they have had in high school but they are not quite as far along in, such as in chemistry or biology.

So preparation, again, is a major barrier, not to just getting in, but to staying in and to achieving, to doing as well as they would like to do.

All our students, when asked what the major barrier to their completion was, inevitable mentioned science courses. Sometimes it was number one, sometimes it was number two, sometimes it was number three. But it always came up as a real problem.

Another problem to completion is what we would consider basic navigational skills. Once a minority student gets into an allied health program, which generally is predominitly white, how do they navigate in that system? How do they tap into the ancillary resources that are there to help them make it?

As we traveled around the Northeast, we had many, many students stay after the sessions and ask us the question: Where can I get scholarship funds? Now, these were students maybe in their third year of a four-year plus internship med tech program. They were juniors already and they were still looking for information on financial aid.

When we met with faculty and students at the same schools, the faculty would tell us about financial aid programs that existed; the students wouldn't know about them.

There is something lacking in the support system, in the communication structure. In instances where it is there, I don't think our students are utilizing it to the maximum available.

I think we also learned a lot from our Lafal technique on how faculty and students perceive the problem differently. One of the basic barriers to completion is that there is a difference in perception and it goes back to the navigational skills.

When you ask faculty about barriers to completion, they do mention financial aid. But it is usually in the past tense. Students mention it constantly, always in the present tense. Faculty perceived that the problems have probably been solved or should have been solved or the admissions officer or the counselor is taking care of them. Students perceived that they are really at see trying to meet their tuition payments, trying to pay for their l was, trying to survive.

Another thing that we found was a notable difference between the students and the faculty was that the students have a very present orie ion

as to the day-to-day nitty-gritty; whereas the faculty were very oriented toward the future, what the career was, what work was like, what people were going to need to get into the career, into work.

Students aren't there yet. Students are still trying to get the program completed. Students are still trying to get through the chem exam next week or whatever kind of exam is coming up, or the mid-term, and into the next semester.

So even once we get the knowledge to the students, even once we get them admitted to the program, there still seems to be some dissonance in our ability to communicate with them, to perceive the ancillary resources they need, to see that they are provided and to get them through the program.

I think basically I have summarized our study in a macrosense -- And I look forward to discussing for the next two-and-a-half days the micro of the study, because there are a lot of little things that we picked up that we were somewhat suprised at.

In summary, if we could get a handle on knowledge, getting the word to the students that the programs are available, where they are offered, how to apply, what they need to get into the program before it is too late, and secondly, if we could make sure that once a student is in, that the support system is there for him, we wouldn't have solved the problem but we would sure be a whole lot farther along. And if we got together five or ten years from now, we would have a lot better representation of the minorities in the allied health professions.

MS. ELISA P. ESLER (Project Director, Research Triangle Institute, Research Triangle Park, North Carolina):

Our methodologies in the different studies of the three contractors differed. This is an identification of perceptions of barriers. As the term indicates, perceptions are the way each person interprets his own experiences. So the way we went about this was asking everyone, "Have you seen and experienced problems in the field of allied health?"

Our method of prioritizing these problem areas was to have each participant rank at the end of the group discussions his/her interpretation of which was his/her most significant problem.

Four findings -- I am going to go right into the findings, because the methodologies have changed and I assume that a lot of questions will come on the details of them in the afternoon and in tomorrow's sessions.

Our general findings were very comparable to the other contractors'. Information and agreement was considerably high between the two different groups, faculty and students.

First, how do we know about allied health? Our counselors simply don't tell us about it. When you are going to a counselor and express interest in the health sciences, they immediately direct you toward medicine, dentistry, or nursing.

Some students don't want to invest eight years of their time in a medical career, and they simply do not have the knowledge of the two and four-year programs in the support allied health professions.

Our second major finding of the four was financial aid. There were several areas of financial aid that were brought up. Prior to entering

a program, how do you complete all those forms that are very, very cumbersome and find yourself having the authority, the school authority, take into consideration only your individual financial aid as opposed to your family financial aid situation?

The second area under financial aid was unexpected expenses that were not identified prior to entering the program - equipment, transportation, clinical rotation. This came out as a very significant problem. It is apparently the fashion now for certain programs to require a clinical rotation for which the student has to pay, I suppose to the hospital, paying a nominal fee or comparable to a regular technician. This is almost upon completion of the program, so the students find themselves rendering equal service for no pay. On the contrary, it is their contribution.

A problem with this is that clinical rotations are not always available in the area in which students are attending their training programs, which implies, then, an additional cost for a field trip to be interviewed, to be accepted. This could be anywhere -- if you are in Georgia it could mean that your clinical rotation is going to be in Washington State. And the obvious difference is in cost of living.

The other problem related to financial aid is dependents. If you have children, if you have a wife, how do you handle the limited BEOG or the other sources? How do you find complementary sources for these? This problem, we are told by our participants, is a reason for dropouts which seems to be higher for minorities.

By the way, we found that many of the programs that we initially contacted had never had a minority member enrolled in any of their programs, and we tried to contact institutions that had four or more allied health programs.

The next major category of problems identified was the basic skills program. And there was a serious disagreement between the two groups, faculty and students.

Faculty tended to rate the lack of basic skills as very significant and most important in the lack of representation of minorities in allied health programs. Whereas the students complain of the fact that some of them had graduated from high school with high academic grades and some of our attendants were semifinalists and finalists in the National Merit Scholarships, they were still made to take a tutorial or remedial program, whereas they felt that their counterpart white students were not made to take such a program.

Their claim was, "Well, I did attend a white school and I did turn out to be a semifinalist or a finalist and I was still registered in this program." So they rated basic skills almost last, consistently. Whereas the faculty group rated basic skills top, consistently.

Our last problem area identified was lack of representation in the allied health professional field in the faculty and in other minority students enrolled. Encouragement: "If I could only see more Black students, Spanish students around to identify with, to give each other encouragement. If there were more faculty that we could go to for advice, not only in relation to academia, but social problems of where do I go to get additional funds. I just had a flat tire -- all of these very nitty-gritty problems that keep popping up related to financial aid."

I had a couple of remarks in general. During the search for socio-demographic data we found, as was mentioned earlier this morning by Mrs. Bear Don't Walk, that there were no statistics available for American

Indians. We did try to invite as many as we could from the areas in North Carolina and in Florida. But we found that the administrative personnel were not terribly eager to send their students or their representatives to the areas where we were going to be holding this conference.

Information turned out to be a great problem for us. There is no available pool of total allied health manpower information from which we can draw any inferences in terms of supply and requirements.

How many more should be trained? And here is something that is very important to me for today's and tomorrow's sessions. Are we here in this group going to be concentrating our interest on increased representation of allied health personnel or increased representation of minorities in allied health?

As was mentioned earlier by Marna Whittington, we have found that most of these problems are true of anyone, any student, and emphasized among students in the lower socio-economic groups and, obviously, further in the racial and cultural groups.

So I would like to try to keep everyone interested in making the distinction between the two: Are we going to find solutions and try to promote development of programs that are oriented towards increasing allied health personnel or minorities in allied health personnel?

MS. BETTY MURRAY (Project Director, Southwest Program Development Corporation, San Antonio, Texas):

As you have heard from Dr. Buckner, the Southwest Program Development Corporation, San Antonio, Texas, did conduct a two-year study of the minority group barriers to allied health careers in the Southwest.

Our study findings are presented by categories of barriers and stages in the process of acquiring professional status, namely the application, the matriculation, and completion. We used a three-phased approach for accomplishing the study over the two-year period.

In Phase I we conducted a review and analysis of the existing literature and compiled an annotated bibliography.

In Phase II a report was prepared on the participation of minority groups in allied health education in the Southwest. The first part was an analysis of the relevant literature and the second part analyzes the allied health student enrollment and allied health workers in the geographic contract area. In Phase II the study methodology was developed. And in Phase III the implementation of the methodology occurred.

The contract as it was modified stipulated that the contractors would implement a series of seven conferences which would be representative of the geographic contract area, for the further illumination of the barriers involved.

A data printout which was provided by the American Society of Allied Health Professions was used in order to determine which institutions to contact. So subsequently, in the Southwest area conferences were arranged in Dallas, Texas; Denver, Colorado; Albuquerque, New Mexico; Oklahoma City, Oklahoma; San Diego, California; Tucson, Arizona; and San Antonio, Texas.

Each conference session was planned to include at least eight participants to meet a goal of 15 participants for each contract area. A total of 183 was projected; 133 actually participated, which gave us a 73 percent attendance rate in the Southwest.

The study population for the seven conferences consisted of two distinct groups. One conference study population was allied health program faculty, allied health program staff and administrators, faculty from the various science departments providing science and mathematics remedial courses, and minority affairs office staff, counseling and supportive services staff and high school counselors and members of community organizations which were in some ways implementing health manpower programs. And in our contract area some nursing program instructors were included.

The other conference study population consisted of the minority students currently enrolled in an allied health program, graduates of an allied health program, minority students who had either left an allied health program or had been terminated before completion, some minority high school students in summer preprofessional courses whose goal was allied health and some, as I mentioned, minority nursing students.

The sex of the participants for the conferences was 54 percent male and 46 percent female.

The ethnic distribution was :

Anglo-American, 12 percent

Black-American, 29 percent

Spanish-American, 47 percent

And Indian-American, only 5 percent.

At the conferences, a brief orientation was given, or rather, an explanation of the study and the purpose and the scope of the discussion sessions was given. The definition of the term "barrier" was stated, as well as the objective of arriving at a priority ranking of barriers by the topic areas.

The priority rankings were determined by group consensus at the conclusion of each session. Thus, the priority rankings that are reflected are the area conference's assessment regarding which barriers should be addressed in order to achieve a comprehensive and far-reaching impact on the underrepresentation of minorities in allied health professions education programs.

The principal findings of the Southwest study regarding priority barriers are summarized as follows: (1) the faculty sessions ranked the lack of appropriate counseling at the high school level, minority student failure to meet institutional and programmatic admission requirements, financial need, and the lack of basic skills in verbal and written communication, the sciences and mathematics as priority barriers; and the student sessions ranked financial need and the lack of financial aid, high school counseling, the allied health curriculum structure and course content, bias against and stereotyping of minorities by faculty and staff, admission requirements, and academic preparation as priority barriers. With respect to the stages involved in achieving professional status in an allied health career, the faculty and students agreed that the most serious barriers occurred in the application stage, with faculty considering both matriculation and completion as including barriers of equal weight and the students citing completion barriers as second ranking and matriculation barriers as third ranking.

Discussion of the individual barriers will take place this afternoon. The other two contractors in their presentations this morning have given you some insight into the content or a description of the barriers as they are delineated, so I will not be redundant in that sense.

I look forward to working with the participants particularly from the Southwest, some of whom are here. And at this time I want to recognize the input that they had, and we are very pleased to have them with us at this conference.

I want to express a great deal of appreciation to them for their input. They shared with us very deeply-felt frustrations. And not only that, they gave us some insight into their geographic area problems.

I also want to thank Don Buckner for his support throughout this contract and I hope that we will have two and a half more days of interesting and worthwhile conference time which will lead in some ways to the elimination of the problems that we are here to solve.

MR. HATCH (Director, Division of Associated Health Professions, Bethesda, Maryland):

I hear several things coming from this session that I think will help us. Obviously the question of who makes decisions with regard to legislation and budgets is not mine, but we do have some discretion.

I hear some things coming through this process that I think will help give us some guidance in where to concentrate those activities with which we do have some discretion.

The things, for example, that Harry Douglass was referring to, with regard to the discussions that were held some four years ago. It's a long time. But, you can have anecdotal feelings about things. What we tried to do here was to derive something in the way of hard information with which we could deal more specifically.

With all the frustrations which you have already discussed I think, just from the discussions this morning and seeing what is on the board here today and some of the prioritization, it will really be helpful for us. I don't think you can ever reach a total consensus on this kind of thing, because there are so many factors that come from one direction or another that are really not controllable from our standpoint.

I am most pleased with what I have heard here. I can only say that we will try to put this in an action mode to the extent that we can.

I, for one, am very happy to see the importance of data being given in this area. One of my great frustrations in the over-all picture of the activities that I deal with is the relatively low level of priority that collecting data has had and the fact that when somebody asks a question, you just don't have the information.

I thank the three regional programs for this. Given their constraints with regard to the problems of collecting information, they did an exceedingly good job of pulling things together. And I congratulate not only them but also ASAHP for this activity. It is not the end.

WORKSHOP REPORTS

The following are the reports of the three working groups:

DR. WHITTINGTON: I think our group had a very good day-and-a-half. I must admit that I faced the whole thing with some trepidation because I wasn't sure how many people would have their own agenda for the sessions and just where people were coming from. But I feel pretty good about it. And as I go through, or at the end, I really would encourage anybody in the group to highlight anything I didn't give enough attention to in my summary or add things that you think are important that I missed, because at times I got caught up in the conversation and, I am sure, didn't do an adequate job of recording. And in summary it is very hard to summarize a day-and-a-half into a cogent group of remarks that isn't going to put everybody else to sleep and yet that gets out everything that you think was important in your day-and-a-half. So please feel free to contribute.

First, I would like to start with an overview of some basic thoughts running through our group, to go to specific solutions, and to then discuss some of the major policies which may be directly related to our problem or indirectly related but worth considering in terms of the whole problem of equal representation of minorities.

In discussing solutions, one thing I would say is that a thought running through the whole group was the need for money, that money was going to solve the problem, to the other extreme, that we just need a lot of money to implement solutions.

Given the tenor of the times now, I think we have seen, with Magnuson's attack on NIE and Proxmire's attack on NSF, that educational research and development is no longer sacred, that more money is no longer considered the solution. So what I have tried to do is specify outcomes or specify goals, with the knowledge that we are going to have to attach a price tag to those, but, that if we go in and say money is the solution, nobody is going to listen to us. We are going to have to say, this is what we want to do, this is the outcome we want and we need so much money to accomplish each of these objectives.

Though I am not going to keep coming back to money in my solutions, I would like you to keep this in mind. I am not ignoring it. I just think we have to have a better approach. I think the urban school situation has shown us where some of the highest per capita expenditure is in the urban school and yet the lowest outcome has resulted.

So money is no longer accepted as the only solution. We are going to have to be really specific as to what we want to do and then how much it costs, as opposed to, we want this much money and with it we are going to do the following.

Secondly, we can't consider solutions independently. We are dealing with what should be a closed-loop system. What solutions we come up with for recruitment are going to impact on the applications. What solutions we come up with for recruitment and applications are going to impact on admissions, are going to impact on matriculation, are going to impact on completion. And they should. We can't decide that we are going to have a no-dropout policy and then decide we are going to have an open entry policy. That doesn't jibe.

We can't decide that we are going to have an open entry policy and then decide that remedial programs are really a problem because people identify with remedial programs.

So I think in all of the solutions, though they may not all be systems-oriented, when we get to the point of putting them together and looking at where our priorities really are, we have to think of the closed-loop system. I will consider each of the steps independently, but in the end when we get done, we have to have something that makes sense in every phase. We can't go out and recruit like mad and then not have the admissions process geared up to admit the people we have recruited to apply. Likewise, we can't get the people to apply and be admitted without having the completion process taken care of, geared up so that the supports that are necessary for someone to complete the program are there.

And in discussing solutions, I also do not want to infer that some programs aren't already doing these things. Some are doing many things; some aren't doing anything.

I think the group concurred that most programs are not doing enough. And I think that the state of representation of minorities really substantiates this.

When we look at potential solutions, we have to define potential solutions so we have a reasonable thing to grab onto and talk about. So in my summary I have dismissed some of the parameters. And I would like to say that the parameters I have dismissed are parameters such as the skills being taught. I think the point was made over and over again that if we address solutions to equal representation, that is the big problem.

It is not the big problem of whether we are talking about PT or OT. So I am going to collapse across all our 20 areas that we did the research on and the many more that were represented in the group.

I think the other point that has to be made, and we made these in our opening remarks, is that the solutions we discuss are not necessarily minority-represented, minority-specified. It is that they are solutions to problems that have a higher probability of occurring for the minority individual because of the economic situation, because of the social situation, because of the family situation, because of the educational situation. So they are not necessarily solutions directed toward minorities. They are solutions directed towards the types of problems or barriers that seem to occur most frequently for minorities.

Also in discussing solutions, I have collapsed across several parameters that in actual implementation are very important, I think.

One of them is the age of the entrant. Are we talking about somebody right out of high school or somebody who has been out in the world, had two, three, four children, and is trying to support those children and re-enter the educational system so that they can enter the labor force in a different capacity? I think, in considering the solutions, that that is going to have to be broken out, but I will not do that today.

Secondly, I think we have to look at the type of program. Is it a hospital program or is it an institutional program? Some of the solutions we came up with are appropriate for one and not the other; some are appropriate for both.

Thirdly, is it a six-month program, a two-year program, a four-year program, or a four year-plus clinical internship or externship type of thing? That also makes a difference in implementation.

What is the program? Is it a people-oriented program? Is it a thing-oriented program? Are we worried about patient interaction skills more than machine interaction skills?

Lastly, the application, matriculation, and completion process is a process, it is not three independent entities. So the solutions in many cases have to be applied to all aspects of the process, as opposed to one specific aspect. In other situations they should be applied to one specific aspect of the process.

In considering recommendations, we have essentially a three-dimensional thing we should look at. We should look at where these solutions should be implemented, who should implement them, and how they should be implemented.

I think one problem our group had was that, as educators, and we were dealing from an educational perspective and educational framework, for the most part. Our solutions initially, before we broke out into sets, tended to be related to the educational system. I think in many instances this is wrong. In many instances for the minorities groups the educational system has failed, the educational system is alien to them, they don't relate well to it.

So I think we should try and break this educational set and try to look at as many other ways to come at the problem as possible.

We are really not dealing with an educational problem; in a sense we are dealing with a market research problem. That is not a very nice thing to say to many people. They consider market research a way to really grab the consumer. But I don't mean it in that sense. I mean we have a product to sell or we have a product to expose a certain group of potential consumers to, and we want them to look at it, we want them to sample it. And if I were a commercial industry and I had a product I wanted to sell, I wouldn't sit back and wait for you to come to me and ask to buy it. And that is the educator's approach. I would take a market research, a selling approach: I am going to get out there and take you and try to get your attention and try to say Sample my products and see what you think, not assuming that everybody is going to buy it, but assuming that nobody is going to buy it unless you have a chance to look at it.

And I think this is something we have to keep in mind with our solutions. They have to be somewhat aggressive solutions.

The first group of solutions I would like to look at is the communication and information transfer system solutions, communications solutions. These solutions go across the board to application, matriculation and completion. Especially in application, we have to take a market research technique.

This is not being done now in many respects and this is not fulfilled by a book published by the Department of Labor that has in it 200 ways to get an allied health career; nor is it solved by the Office of Education publishing a book on where or how to get into allied health careers.

First, in order to respond to that educational elitism kind of structure, one has to know they want it. One has to know it is available. One has to know where it is available and one oftentimes has to have the money necessary to send for it. It may only be $2, but that is $2, plus a stamp, soon to be a 13-cent stamp.

So in our communications and information transfer system solutions, our group tried to orient themselves towards other ways to communicate, aggressive or active ways as opposed to passive you-come-to-me-for-information kinds of ways.

There were several programs that have been very successful in this aspect that have been brought up. One of them was a program tack in Connecticut where they actually went out and sought students, minority students, who were not what we consider by traditional criteria high-potential students, i.e., they had low grade point averages. The program tried to motivate them twoards thinking about allied health careers.

Another program entering at the sophomore level offered a special day for allied health careers for minorities.

We also thought of several things outside the educational system. For example, if you go into a minority area, a minority residential area, what mechanisms can you use for grabbing somebody's attention?

Last year Ebony Magazine published an article on financial aid for students. Every student we talked to knew about that article. Every student we talked to either had access to that article through a family or knew how to access that article through a local corner newsstand or drugstore. We ought to try to use that kind of medium.

One suggestion that was brought up was that a program had published an article in the Sunday newspaper magazine supplement. They were deluged with requests. Apparently a lot of families buy the Sunday newspaper. That not only appealed to the students involved, but many of the parents reacted to that. I think we ought to think about that.

If you go into a ghetto situation, everybody seems to walk around with a transistor radio glued to their ear. How can we use that medium? That medium presents some kind of problem because it requires followup, but it is one medium that we haven't traditionally talked about using.

I think that we have to think about both those kinds of things inside and outside the educational system. Our initial thoughts on inside the educational system were, Let's get away from counseling; counseling sometimes has a negative valence. Let's go to science teachers or even boost up the high school counseling. But already you have selected out many of your minorities. So let's think down in age, let's think of teachers or people who have contact with these students prior to their being tracked in a system where they don't get science courses, prior to their being homogeneously arranged in groups that are more appropiate for the educational process. I think we have to start thinking younger in many respects

We also had a lot of good suggestions on community resources. One particular suggestion was the allied health program students, I believe, conducted screening clinics for sickle cell anemia and that kind of thing in the community. This would be a good vehicle. One, you have got your role model. Two, you got information transfer, person-to-person contact. Why not use this mechanism?

Secondly, religious organizations are potential mechanisms. Thirdly, community health centers. Oftentimes, our potential clients sit for three hours in community health centers reading comic books, watching cartoons on the TV. Can we better access or utilize that time?

I think the communications systems problem also goes into the matriculation and the completion process. It is not just oriented towards recruitment. But I am going to discuss that later under a different heading as the program structure. So I don't mean to leave that out at this point. Those suggestions are coming in later.

I do think there are a lot of potentially good things being done from which we can learn. For example, in Philadelphia they have what is called Super Sunday and every cultural and ethnic group goes out and has their dances, their food displays. The art museum puts in a big plug for the art museum. But you know who else is there? The Army and the Navy and the Air Force recruiters. They spend millions of dollars every single year trying to determine the best way to access potential recruits. And they are there. They are not getting their recruits through the traditional educational system. And I think there is something to be learned from their techniques and their mechanisms.

Enough for communications and information for the time being.

I think the next category of solutions I would like to discuss is the structure of the actual programs. Once you have got somebody recruited, what about admissions? How should we impact on the admissions process?

I think our group was a little bit stymied on this one because we all agreed that we weren't real happy with GPAs, we weren't real happy with SAT scores and we weren't real happy with [illegible].

There are ways that you can upgarde all those three, such as minority representation on the admissions committees, which apparently in many instances is not there. Secondly, minority representation as interviewers. Thirdly, taking the interviewer to the student, rather than requiring the student to come to the interviewer. A 200 or 300 or 400-mile trip becomes expensive. It also becomes a barrier in senses other than money.

Another suggestion for reaching the students in the interviewing process involved using other students or using faculty or representatives from other schools in the same locale as the student. Have the student go to them, as opposed to having your interviewer go out to the student, because many times that is not feasible.

We also had the suggestion of an open-door policy. There are problems with that, I realize. But that is one approach to the solution.

Another point raised was how to specify minority status on the applications. Apparently it is very difficult at many schools' application process to tell whether somebody is a minority member or not. And we went through that whole process where you didn't put any pictures and you didn't put what background you had, etc. And now, since we have swung back the other way, maybe it would be of benefit to find out the minority status of an individual.

As I said, I don't think we were totally happy with our solutions to the admissions problems. We would like to find other ways of measuring a person's potential professional capabilities, but we didn't come up with any.

The third category of solutions we had was structure of the program.

Currently, there seems to be in the educational system a lot of emphasis on open entry, open exit, competency-based individualized instruction. But that has reached the allied health programs, for the most part, only within a course as opposed to within a program. Within a given course, you often have individualized instruction or competency-based instruction, but the program itself is still a very lock-step program. For the student who doesn't have the background or the student who has to work, there is no way to take three years to accomplish that two-year program; the mechanism isn't there. This might be a good mechanism to attract individuals who do not have all the basic skills necessary to take a full course load and to keep up. Such a mechanism might also attract individuals who have to work who need additional financial support other than that which the program is providing.

A no dropout policy. Our group seemed to feel that once a person had made it through the application and acceptance procedures, the school really should have a commitment to that student to do whatever possible to see that they completed the program.

Guaranteed clinical affiliation. And I think this was particularly true with medical lab tech. We had a lot of comments on that, but with the other programs requiring lab affiliations also.

Once a person has satisfactorily gotten through their course work, it shouldn't be that they are in the top 15 of 20 and therefore get a clinical affiliation spot. If 20 people in a class satisfactorily complete their course work, there should be 20 clinical affiliations for those individuals. This should not be another weeding-out point in the process.

Another point that we had a lot of discussion on was course content or course structure. It is really necessary for allied health students to take chemistry courses, biology courses, anatomy courses with the pre-medical students or pre-dental students?

There are a lot of aspects to this problem. The first is, Do they need all the same course work? But I think there are some other considerations. The allied health students have already been accepted into their professional program. And if you accept the philosophy of no dropouts, they are there to complete. The pre-medical students are still, if you want to use the analogy, at the high school stage, when you compare them to allied health. The philosophy in those programs is oftentimes to weed out those pre-medical or pre-dental students. Oftentimes the courses are curved. There is a lot of competition. There is not a lot of group feeling of helping each other.

So, the content per se, as well as, the philosophy with which the course is given, are being called into question. It is appropriate for an allied health student?

Another thing we wanted with the structure of the program was an early warning system for academic problems. Too often the student or the faculty member is aware of academic problems and it is pretty well on in the semester and there is no early warning system to help that student get up to speed before he is way behind.

In this vein, we had some discussion of whether a student should be allowed to resign from a course within a week of the end of the semester. This was a problem in several senses: (1), if a student always knew he had this out, he might play on the [illegible]

lot of dissipation of intellectual activity and energy. If you are failing a course but you wait until the next-to-last week to drop, you have used a lot of energy that last half of that semester on that course that could have been better given to other courses that you may not have been having problems in, you may have just been sort of getting along in.

So that policy, we thought, really should be looked at. Not that you shouldn't be able to resign from a course, but that halfway through the semester might be a more appropriate time to decide that you are going to resign or that you are going to see it through.

Included in this support system is a need for peer group support. This is not just academic peer group support but a social, psychological peer group support. There isn't a mechanism for peer group support of students.

Then we are back to our old problem of adequate financial aid. If a student has to work, potentially he/she can't carry the course load. A student should have adequate financial aid and not be put in the bind of, Do I work and flunk, or not work and have to drop out.

Also some consideration should be given to financing special situations. For example, the student who can only get his year of clinical affiliation 300 miles away has to travel 300 miles away and somehow live, and that costs money.

The student who has to get to a clinical affiliation or a part of their program that requires a car because there is no public transportation should be afforded some financial consideration.

There are other kinds of special expenses associated with the allied health programs that we should consider in awarding financial aid.

The whole question of tutoring and remedial work, the quality and quantity of it, is a real problem. The group had some really good thoughts on the notion that tutors are selected because they are doing well in the course, not because they can tutor. We should really re-examine the tutoring system to make sure that it offers the highest quality of helping for the smallest quantity of time, because oftentimes the students cannot afford to spend a lot of time getting extra tutoring for one course.

Basically, I think that pretty well captures the broad groups of solutions that our group came up with.

There was a lot of specific discussion on how things should be implemented, where they should be implemented, who should implement them. And I think the thought was that we should not only look to the educational system, to counselors and teachers to implement them; we should look at professional associations to implement some of these things. We should look at the accreditation process. Can some pressure be brought to bear to bring about some of the solutions to the accreditation process? Legislation. Is there some way that legislation can address some of these issues? That we shouldn't go back to the traditional "who's" in the process of implementation.

In summary, we had some major policy issues that were interwoven through all our solutions and are fairly important to consider in both implementing them and thinking about solutions.

One is that, since we do have limited dollars, how do we allocate them in the application, matriculation, completion process? How do you determine the best way to allocate them?

Secondly, are we recruiting for allied health or are we recruiting minorities for allied health? And is there a difference? How do you distinguish between the two?

Thirdly, should where the minority individual is going to practice be an issue? This is very interrelated with the whole admissions problem.

If you look at admissions and you use as one of the admissions criteria the potential group to be served by the applicant (which maybe a good admissions criterion), then we have to think about what we are implying. Are we implying that the minority individual has to go gack and serve a minority? And, secondly, even if we did not make that a criterion; the minority groups tend to have less good health services, are less able to consume those that are available, and have fewer available to consume. How do we sell the potential benefits of a minority member going back to serve a minority, once they have their professional degree and capabilities -- how do we increase those benefits, how do we make it more attractive?

Fourthly, how are we going to monitor the impact if we decide to do something? And I think we are all optimistic that we will decide to do something. How are we going to monitor the impact of what we do and decide whether it is worthwhile doing or whether those dollars should be redirected.

And lastly, a question I think we all ought to think about is, how do we know when we have met our goals? First, how do we set our goals? And then, how do we know when we have met them? What are we going to use as criteria? Are we going to use numbers or are we going to use numbers in occupations? Are we going to use numbers in salaries?

I think before we can implement any solutions or think about any solutions, we have to look at where we are trying to go, what are our goals, and how are we going to monitor whether we are getting to our goals? And then I think we can better allocate our dollars to our solutions in order to fulfill those goals.

MRS. ESLER: Before I get involved in the results from our last two days of discussions, I would like to thank the Division of Associated Health Professions for expressing their concern and commitment to this problem that we have been discussing for the past couple of days by funding and facilitating the implementation of the four contracts.

I would also like to thank the American Society of Allied Health Professions for hosting this conference and for accommodating my request to invite students from each of the states that we visited and hear their input into the discussions and the solutions offered.

Last but not least, I am very appreciative of the articulate group of individuals who not only attended our sessions, but also actively participated in dealing with the problems in the Southeast.

Our group was primarily concerned with policy at national and local levels to break barriers of admission and finances that keep our three populations of concern - Indians, Spanish-Americans and blacks - out of the mainstream of health manpower in America. It is not until these impediments have been dealt with that efforts to improve outreach and academic procedures can be refined. Why? Because one can go out and identify any number of qualified, highly competent and interested students in allied health; but if the training institutions are not ready to accept these students and finance the completion and their program certification in their professional area, all other efforts run the risk of becoming futile exercises.

In one very, very general statement, the outcome of our discussions determined one very, very large need: intervention at the local level to

attempt to make adequate changes in the various political systems that govern us.

We have until noon today to listen to the three solutions that were identified by the three groups and let Dr. Don Buckner try to lead us into some consensus from the whole group.

We came up with ten resolutions, which I would like to read to you in the order in which they were given to us, prioritized by our group, and in the wording of the group. I am sure that at the end of this reading any one of the members of our group will feel very, very comfortable getting up and reminding me if I have left anything out.

In order of priority, the Southeastern working group proposes the following resolutions to deal with the problems identified:

-- That the American Society of Allied Health Professions develop explicit advocacy to overcome the barriers to minority students enterin allied health professions and take steps to oversee the implementation of these policies.

-- That federal and state funds be facilitated only to allied health programs which provide a policy of equal access to minorities as reflected in minority enrollment proportional to the immediate population or populations to be served.

-- That federal, foundation, or other capitation resources be allocated to training institutions as a reward for enrolling minority students and insuring that students complete their program and be registered in their appropriate professions.

-- That establishment of state organizations be initiated a) to disseminate existing and new information to the general public and elementary schools with a special mandate to inform minority population and b) to coordinate existing mechanisms and use of existing professional organizations such as the Association of Admission Officers and Registrars and the Association of Guidance Counselors. The American Society of Allied Health Professions at the national level should commit itself to the support of these state organizations.

-- That a strategy be developed and enforced to identify and remove admission criteria and procedures that are culturally biased.

-- That new legislation be created for allied health trainingships, with specific funding for ancillary clinical and training expenditures. The American Society of Allied Health Professions should promote such legislation and inform its allied health constitutency of the progress of the proposed legislation and need for support from state and local levels.

-- That current efforts be expanded to include distribution of a summary of the results of this conference to educational and other appropriate journals, systems of instruction, and other interested parties.

-- That strategies be developed for the establishment of cooperative arrangements between minority schools and allied health programs in order to provide allied health training for minority students at schools without allied health programs.

-- That strategies be developed for the establishment of cooperative arrangements between minority colleges and health care institutions in order to provide allied health training [illegible]

-- That under sponsorship of the Division of Associated Health Professions, definitive statistical documents be developed which encompass the population in the area of allied health personnel by discipline, certification, licensure, registration, ethnic background, geographic location, sex, age, and other relevant parameters. This quarterly information should be distributed through the Journal of Allied Health and reprints be sent to state offices of higher education, administrators of post-secondary schools, counselors and other offices and individuals involved in the training of minorities in allied health.

MS. MURRAY: As workshop leader for the Southwest Region sessions and on behalf of my associates from Southwest Program Development Corporation, Mrs. Martha Reyes and Mr. Henry Travieso, we wish to acknowledge and express appreciation to the Southwest Regional Task Force members for the patience and the seriousness and the diligence which they individually and collectively applied to the accomplishments of the tasks that were set before us two days ago. And we particularly wish to express appreciation to Mrs. Marjorie Bear Don't Walk for sharing her concerns for the health and nutrition needs of minority students as they affect learning abilities.

The Southwest Region Task Force has delegated me to be their spokesman and has requested that, prior to reporting work session results, the following recommendations and suggestions be presented to the Division of Associated Health Professions and the American Society of Allied Health Professions.

First - That the Division of Associated Health Professions keep Task Force members informed of project study outcomes and that Task Force members be utilized as resource persons in designing programs to increase minority allied health professionals.

Second - That the American Society of Allied Health Professions actively disseminate the national study findings at the federal, regional, state and local levels and to the appropriate professional associations.

And, further, that the project study reports as presented by each region remain intact.

The Task Force members had three tasks to perform: barriers identification, the development of solutions, and the prioritization of those solutions.

Briefly, the Task Force utilized the following process to arrive at the priority solutions. The first process was the validation of barriers as delineated in the Region's final report, and they were ranked in the following order:

First - Perception and knowledge of allied health and counseling.

Second - Academic preparation.

Third - Financial aid.

Fourth - Institutional recruitment and admission practices.

Fifth - Institutional financial aid practices.

Sixth - Institutional retention practices and the lack of comprehensive supportive services.

Next, an analysis of identified barriers and group consensus on barrier components was done. This was followed by a functional analysis of barriers in relation to the process of pre-admission, admission, and completion of an allied health program.

Two sets of recommendations are to be set forth from these sessions. The first deals directly with the dearth of minority allied Health manpower information, and the second set is programmatic, addressing the barriers as defined and the prioritized solutions developed.

The Southwest Region Task Force recommends to the Division of Associated Health Professions:

First - That the Division should initiate appropriate steps to insure [illegible] data requir[illegible] are developed on allied health manpower

to include minority group representation in allied health professions and the geographic distribution of minority allied health workers.

This recommendation addresses the need for base line data and for the impact evaluation of programmatic efforts to increase minority allied health professionals.

Second - That a national comprehensive allied health manpower development program be implemented and that the program elements include: the collection of statistics on minorities in allied health professions education programs, the development of universal definitions of allied health careers, and the standardization of certification and registry requirements, the development of public information programs to provide minorities with information and counseling on allied health careers, academic requirements, costs of programs and financial aid sources.

The informational materials would be specifically designed with cultural and linguistic appeal.

And, finally, it should provide for federally funded comprehensive supportive services for minority students. Comprehensive supportive services would centralize the delivery of such services as financial assistance, health and nutrition services, consumer education, housing and transportation, child care, allied health course tutoring, and alternative-career counseling, among other things.

The Southwest Region solutions recognize the system changes that must occur in society, in educational institutions and in the economic base. And we are addressing the immediate need for remediation efforts in increasing minority allied health professionals.

The contractor and the Southwest Region Task Force therefore propose that the Division of Associated Health Professions reiterate its commitment to increasing minority group representation in allied health professions by developing and implementing national-impact action plans and regional programmatic efforts to address the complexity of problems identified in this national study by the three contractors and confirmed by the Task Forces.

APPROACHES RECOMMENDED IN MINORITY BARRIERS IDENTIFICATION CONFERENCE

In determining priorities of the workshop recommendations, the conferees utilized the Nominal Group Process.

This process conducted by Dr. Buckner afforded the opportunity for each participant to determine his own recommendations by rank order. In turn, the rank orders of all of the participants were consolidated and the results were clear choices of the group as a whole as to the ranking of priorities of the recommendations.

The priorities determined by the Nominal Group Process are:

1. Initiation of a national comprehensive Allied Health manpower development program that would include: (a.) statistics relating to minorities in Allied Health educational programs; (b.) universal definition of the Allied Health Professions and certification standards and registration requirements; (c.) counseling programs to provide minorities with information as to Allied Health careers, academic requirements, training costs, and financial resources; and (d.) the provision of Federally funded comprehensive supplemental services for minority students, such as financial assistance, counselor education, alternative career counseling, tutorial services, child care, housing and transportation, and health and nutrition services.

2. Development and enforcement of a strategy to identify and remove culturally biased admissions criteria and procedures, such as more effective entrance criteria in relation to the GPA, SAT, and interviews; adequate minority representation on admissions committees; and, interviews held near students homes

3. Public or private capitation resources for training centers based on completion of training programs and registration in a profession by minority students.

4. Development and implementation of advocacy programs to overcome barriers to minority students entering the Allied Health Professions.

5. Allied Health traineeships that would include specific funding for ancillary clinical training costs.

6. The utilization of state-level organizations in dissemination of new and existing information regarding Allied Health educational programs to both the schools and public-at-large; coordinating such efforts with the existing mechanisms and professional societies.

7. The development of standardized data about Allied Health manpower that includes minority group representation withing the Allied Health Professions and the geographic distribution of minority groups employed as Allied Health Professionals.

8. The development of information transfer systems, both active and passive, and at various levels of detail. The systems would be formal (e.g., educational systems, libraries, state and professional organizations), informal (e.g., periodicals, exhibits, radio-TV), and community groups (e.g., religious, civic).

9. The development of strategies that would establish cooperative arrangements between schools with sizable minority populations and health care institutions for the training of minority students in an Allied Health Profession.

10. The development of strategies that would establish cooperative arrangements between schools with sizable minority populations but no Allied Health educational programs and schools of Allied Health to pro-

vide training programs for minority students in an Allied Health Profession.

11. An examination of program structures with the objective of increasing flexibility such as open entry/open exit, no drop policy, guaranteed clinical affiliations, and competency based instructions.

12. Distribution of materials describing the efforts of this conference and its recommendations be made available for distribution to educational and professional periodicals and journals, systems of instruction, and all other interested persons and agencies.

13. Development of comprehensive support systems for minority students in Allied Health educational programs that would include advocates, advisors, peer support, tutors, fiscal assistance, and early warning of problems.

14. Development of statistical decumentation regarding populations within the Allied Health Professions and that distribution be made through publications and to agencies and institutions involved in the training of minorities in Allied Health Professions.

15. Assurances that public funds be allocated only to programs providing equal access to minority students.

16. Examination of course structure wherein Allied Health students compete with pre-med, pre-dental, and pre-veterinary students to determine if Allied Health students need all of the course content given to pre-med, pre-dental, and pre-veterinary students.

17. Development of a closed looped system for increasing minority student representation through recruitment, application, matriculation, and completion.

AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

ONE DUPONT CIRCLE, WASHINGTON, D.C. 20036 TELEPHONE: (202) 293-3422

EXECUTIVE DIRECTOR
WILLIAM H. SAMUELS

PRE-REGISTRATION LIST
(as of December 11, 1975)

INVITATIONAL CONFERENCE

CONCERNED WITH

MINORITIES' BARRIERS

IDENTIFICATION

December 15-17, 1975
Pentagon Quality Inn
Arlington, Virginia

CYNTHIA ADAMS
University of Connecticut
Storrs, CT

DR. E. LAVONIA ALLISON
North Carolina Health Manpower Dev. Program
Chapel Hill, NC

DR. ALONZO ATENCIO
University of New Mexico School of Medicine
Albuquerque, NM

SHIRLEY AYKINS, PH.D.
University of Pittsburgh
Pittsburgh, PA

L. YVONNE BACARISSE
Florida International University
Miami, FL

PROF. RUTH E BAINES
State University of New York
Stony Brook, NY

DR. HERMAN G. BRANT
Laredo Junior College
Laredo, TX

EDWARD BROWN, JR.
State University of New York
Stony Brook, NY

WALTER M. BROWN, PH.D.
Washington, DC

WILLIE V. BRYAN, ED.D.
University of Oklahoma
Oklahoma City, OK

DR. L. U. CHANDLER
Fayetteville State University
Fayetteville, NC

GUS CHAVEZ
San Diego State University
San Diego, CA

DELORES CLARK
State University of New York
Buffalo, NY

ARLENE CROSS, R.N.
Hillsborough Community College
Tampa, FL

ELLEN DARROW
University of Connecticut
Storrs, CT

RUSSELL J. DAVIS
Howard University College of Medicine
Washington, DC

DR. LEON DINGLE, JR.
Rush University
Chicago, IL

DWIGHT DIXON
State University of New York
Brooklyn, NY

HARRY E. DOUGLASS, III
Howard University
Washington, DC

DR. FRITZ H. EHREN
University of Central Arkansas
Conway, AR

LUCILLE L. ETHERIDGE, R.N.
National Assoc. for Practical Nurse Educ. & Service
New York, NY

HARLEY E. FLACK, PH.D.
Howard University
Washington, DC

THOMAS E. FREELAND, PH.D.
University of Mississippi Medical Center
Jackson, MS

WAVERLY FUTRELL, M.S.
Montefiore Hospital and Medical Center
Bronx, NY

PATRICK GARCIA
San Diego State University
San Diego, CA

STEVEN A GARFINKEL
Research Triangle Institute
Research Triangle Park, NC

DR. JAMES GILLIGAN
Central Florida Community College
Ocala, FL

CAROL HACKWORTH
Tuscon, AZ

MARGARET B. HARTY
Texas Women's University
Denton, TX

THOMAS D. HATCH
Div. of Associated Health Professions
Bethesda, MD

ALFRED HERNANDEZ
Incarnate Word College
San Antonio, TX

LLOYD G. HILL
Oscar Rose Junior College
Midwest City, OK

HOFFLER
National Institute of Health
Rockville, MD

EVERLEEN N. HOLMES, R.R.A.
Eastern Kentucky University
Richmond, KY

EDGAR J. JORDAN, JR.
University of Southwestern Louisiana
Lafayette, LA

JOAN JOYCE, R.N.
Hillsborough Community College
Tampa, FL

JOSEPH KADISH, ED.D.
Bethesda, MD

STANLEY S. KATZ
Quinnipiac College
Hamden, CT

JESSE KING
Washington Technical Institute
Washington, DC

REAR C. LACHAPELLE, PH.D.
University of Vermont
Burlington, VT

[illegible]

JOSEF L. MANDEL
North Carolina Health Manpower Dev. Program
Pembroke, NC

BRUCE M. MANICO
Medical University of South Carolina
Charleston, SC

JOHN P. MARTIN, ED.D.
College of Medicine and Denistry of New Jersey
Newark, NJ

PAUL R. MEHNE, PH.D.
East Carolina University
Greenville, NC

SUSAN MELASHENKO
University of Maryland Health Center
College Park, MD

GREGORY E. MERRIWEATHER
The George Washington University
Washington, DC

BESS MORRIS
Tuscon, AZ

KENT D. NASH
Research Triangle Institute
Research Triangle Park, NC

LARRY NUTTER
Oscar Rose Junior College
Midwest City, OK

FRED W. PARKER, JR., R.T., M.S.
Medical University of South Carolina
Charleston, SC

JANIS PAYAN
University of Colorado Medical Center
Denver, CO

DR. K. RAJASEKHARA
Barber Scotia College
Concord, NC

PATRICK C. RUNDE, PH.D.
University of Wisconsin-Madison
Madison, WI

CAROLYN A. RUSSELL
Project Black Awareness-Health Careers
Birmingham, AL

WARREN C. SMITH
American Corrective Therapy Assoc.
Alexandria, VA

STEPHEN D. SNEED
State University of New York
New York, NY

DR. HOWARD K. SUZUKI
University of Florida
Gainesville, FL

PAULA M. SWAIN
University of Oklahoma
Washington, DC

NORMA TIGERMAN
California State University
Fresno, CA

DR. LUCILLE H. TUNSTALL
Clark College
Atlanta, GA

RUSSELL T. WERNER
Northampton County Area Community College
Bethlehem, PA

DR. MERLE WHITE
Northampton County Area Community College
Bethlehem, PA

PEGGY C. WILSON
Ohio State University
Columbus, OH

JOHN H. WORD, L.P.N.
Nat. Assoc. for Practical Nurse Educ.
and Service Inc.
New York, NY

FRANK H. WRIGHT, JR.
Duke University
Durham, NC

LINDA BERGAL YARDLEY
University of Colorado Medical Center
Denver, CO

AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

ONE DUPONT CIRCLE, WASHINGTON, D.C. 20036 TELEPHONE: (202) 293-3422

EXECUTIVE DIRECTOR
WILLIAM M. SAMUELS

ADDENDUM SHEET

REGISTRATION LIST

GAIL ANDERSON
University of Alabama
Birmingham, Alabama

RACHEL BETTIS, M.P.A.
Hospital League
New York, New York

JOHN COFFEE
Howard University
Washington, D.C.

FELIPE DURAN, JR., M.S.
El Paso Community College
El Paso, Texas

VIRGINIA MCILROY
Northampton County Area Community College
Bethlehem, Pennsylvania

DWIGHT KAMBACK
Northampton County Area Community College
Bethlehem, Pennsylvania

DR. SHIRLEY MARKS-BROWN
Harvard School of Public Health
Boston, Massachusetts

MONICA L. STALLWORTH
University of Minnesota
Minneapolis, Minnesota

JOAN C. STOLITZA
University of Minnesota
Minneapolis, Minnesota

ROBERTA COTTMAN
Wayne State University
Detroit, Michigan

REBECCA GARREON
St. Philips College
San Antonio, Texas

GARNER
St. Philips College
San Antonio, Texas

MRS. REYES

MR. TRAVIESO

SPEAKERS

MARJORIE BEAR DON'T WALK
Helena, Montana

STEPHEN D. BENSON, PH.D.
Associates for Research in Behavior, Inc.
Philadelphia, Pennsylvania

DONALD R. BUCKNER, ED.D.
Division of Associated Health Professions
Bethesda, Maryland

ELISA P. ESLER
Research Triangle Institute
Research Triangle, North Carolina

RICK LAVIS
Senior Legislative Assistant to
Senator Paul J. Fannin (R. Ariz.)

BETTY MURRAY
Southwest Development Corporation
San Antonio, Texas

MARNA C. WHITTINGTON,PH.D.
Associates for Research in Behavior, Inc.
Philadelphia, Pennsylvania

AMERICAN SOCIETY OF ALLIED HEALTH PROFESSIONS

THOMAS C. BARKER, PH.D.
President
Richmond, Virginia

WILLIAM M. SAMUELS
Executive Director
Washington, D.C.

LYN GETCHELL

RICHARD HUGHES

ELIZABETH TAGG

CE 004 373